

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

| 1. PATIENT INFORMATION | | | | 2. REASON FOR VISIT | | | |
|---|-----|--|--|---|--|--|--|
| a. Date of visit | | e. Ethnicity | | Patient's complaint(s), symptom(s), or other reason(s) for this visit – Use patient's own words. (1) Most important: (2) Other: (3) Other: | | | |
| Month | Day | Year | | | | 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino | |
| b. ZIP code | | f. Race – Mark (X) one or more. | | | | | |
| | | 1 <input type="checkbox"/> White 4 <input type="checkbox"/> Native Hawaiian/ 2 <input type="checkbox"/> Black/African American 5 <input type="checkbox"/> American Indian/ 3 <input type="checkbox"/> Asian 6 <input type="checkbox"/> Alaska Native | | | | | |
| c. Date of birth | | g. Does patient use tobacco? | | | | | |
| Month | Day | Year | | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | |
| d. Sex | | h. Primary expected source of payment for this visit – Mark (X) one. | | | | | |
| 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male | | 1 <input type="checkbox"/> Private insurance 5 <input type="checkbox"/> Self-pay 2 <input type="checkbox"/> Medicare 6 <input type="checkbox"/> No charge/Charity 3 <input type="checkbox"/> Medicaid/SCHIP 7 <input type="checkbox"/> Other 4 <input type="checkbox"/> Worker's Compensation 8 <input type="checkbox"/> Unknown | | | | | |
| 3. CONTINUITY OF CARE | | | | | | | |
| a. Are you the patient's primary care physician? | | b. Has the patient been seen in this clinic before? | | c. Major reason for this visit | | | |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | 1 <input type="checkbox"/> Yes, established patient – How many past visits in the last 12 months? Exclude this visit. 1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1-2 3 <input type="checkbox"/> 3-5 4 <input type="checkbox"/> 6+ 5 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient | | 1 <input type="checkbox"/> Acute problem (<3 mos. onset) 2 <input type="checkbox"/> Chronic problem, routine 3 <input type="checkbox"/> Chronic problem, flare-up 4 <input type="checkbox"/> Pre-/Post-surgery 5 <input type="checkbox"/> Preventive care (e.g., routine prenatal, general exam, well-baby, screening, insurance exam) | | | |
| Was patient referred for this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | | Episode of care 1 <input type="checkbox"/> Initial visit for problem 2 <input type="checkbox"/> Follow-up visit for problem 3 <input type="checkbox"/> Unknown | | | |
| | | | | d. Do other physicians share patient's care for this problem or diagnosis? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | |
| 4. INJURY/POISONING/ADVERSE EFFECT | | | 5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT | | | | |
| a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment? | | b. Cause of injury, poisoning, or adverse effect – Describe the place, intentionality, and events that preceded the injury, poisoning, or adverse event (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, wife beaten with fists by husband, heroin overdose, infected snail, etc.). | | As specifically as possible, list diagnoses related to this visit including chronic conditions. | | | |
| 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – SKIP to item 5. | | | | (1) Primary diagnosis: (2) Other: (3) Other: | | | |
| 6. DIAGNOSTIC/SCREENING SERVICES | | | | | | | |
| Mark (X) all ordered or provided at this visit. | | | | | | | |
| 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> General medical exam 3 <input type="checkbox"/> Other exam – Specify site (e.g., breast, rectal) _____ 4 <input type="checkbox"/> Temperature Specify _____ | | 5 <input type="checkbox"/> Blood pressure – Specify _____ 6 <input type="checkbox"/> Urinalysis (UA) 7 <input type="checkbox"/> Urine culture 8 <input type="checkbox"/> PAP test 9 <input type="checkbox"/> Cervical/Urethral culture 10 <input type="checkbox"/> PSA (prostate specific antigen) 11 <input type="checkbox"/> Hematocrit/Hemoglobin | | 12 <input type="checkbox"/> CBC (complete blood count) 13 <input type="checkbox"/> Lipids/Cholesterol 14 <input type="checkbox"/> Glucose 15 <input type="checkbox"/> HgbA1C (glycohemoglobin) 16 <input type="checkbox"/> Electrolytes 17 <input type="checkbox"/> Other blood test 18 <input type="checkbox"/> EKG/ECG (electrocardiogram) 19 <input type="checkbox"/> Throat culture/Rapid strep test 20 <input type="checkbox"/> Stool culture 21 <input type="checkbox"/> X-ray | | | |
| | | | | 22 <input type="checkbox"/> Mammography 23 <input type="checkbox"/> Other imaging 24 <input type="checkbox"/> Scope procedure (e.g., colonoscopy) – Specify _____ 25 <input type="checkbox"/> Other service – Specify _____ | | | |
| 7. COUNSELING/EDUCATION/THERAPY | | | 8. SURGICAL PROCEDURES | | | | |
| Mark (X) all ordered or provided at this visit. Exclude medications. | | | List up to 2 surgical procedures ordered, scheduled, or performed at this visit. | | | | |
| 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Asthma education 3 <input type="checkbox"/> Diet/Nutrition 4 <input type="checkbox"/> Exercise 5 <input type="checkbox"/> Growth/Development 6 <input type="checkbox"/> Mental health/Stress management | | | 1 <input type="checkbox"/> NONE (1) (2) _____ | | | | |
| 7 <input type="checkbox"/> Physiotherapy 8 <input type="checkbox"/> Psychotherapy 9 <input type="checkbox"/> Tobacco use/exposure 10 <input type="checkbox"/> Weight reduction 11 <input type="checkbox"/> Other | | | 1 <input type="checkbox"/> Ordered/Scheduled 2 <input type="checkbox"/> Performed 1 <input type="checkbox"/> Ordered/Scheduled 2 <input type="checkbox"/> Performed | | | | |
| 9. MEDICATIONS & INJECTIONS | | 10. VISIT DISPOSITION | | 11. PROVIDERS SEEN | | | |
| a. What is the total number of drugs prescribed or provided at this visit? _____ Number of drugs <i>Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit.</i> | | Mark (X) all that apply. | | Mark (X) all that apply. | | | |
| b. List up to 8 medication/injection names below. | | 1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return if needed, PRN 3 <input type="checkbox"/> Refer to other physician 4 <input type="checkbox"/> Return at specified time 5 <input type="checkbox"/> Telephone follow-up planned 6 <input type="checkbox"/> Admit to hospital 7 <input type="checkbox"/> Other | | 1 <input type="checkbox"/> Staff physician 2 <input type="checkbox"/> Resident/Intern 3 <input type="checkbox"/> Other physician 4 <input type="checkbox"/> RN 5 <input type="checkbox"/> LPN 6 <input type="checkbox"/> Medical/Nursing assistant 7 <input type="checkbox"/> Nurse practitioner/Midwife 8 <input type="checkbox"/> Physician assistant 9 <input type="checkbox"/> Medical technician/technologist 10 <input type="checkbox"/> Other | | | |
| (1) _____ (5) _____ (2) _____ (6) _____ (3) _____ (7) _____ (4) _____ (8) _____ | | | | | | | |